STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING -- B. WING	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/08/24 Facility Number: 012466 Provider Number: 155786 AIM Number: 201014060 At this Emergency Preparedness survey, Allisonville Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 161 certified beds. At the time of the survey, the census was 134. Quality Review completed on 02/12/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/08/24 Facility Number: 012466 Provider Number: 155786 AIM Number: 201014060 At this Life Safety Code survey, Allisonville Meadows was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
keith davis	Senior executive director	02/23/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 161 and had a census of 134 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 02/12/24			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other 1. Based on observation and interview, the facility failed to ensure 1 of 1 electric range in the therapy area was free of combustible material and other debris. LSC 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect up to 10 residents and staff in the therapy area. Findings include: Based on observations and interview during a	K 0100	We respectfully request desk review in this matter. Thank you for your consideration. 1) what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - no residents were affected by this alleged deficient practice. - the cookie box in question was immediately removed. lint removed from the floor , walls and ceiling in question in the laundry area. 2) how will you identify other residents having the	02/24/2024

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	tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., the electric range in the therapy area, with power supplied to the appliance, had placed on the electric burners a paper cookie box in direct contact with the burners failing to minimize the possibility of a fire emergency relating to the aforementioned appliance. The MD acknowledged the condition and removed the box from the burner. The findings were reviewed with the Maintenance Director at the time of discovery and again with the MD and Senior Executive Director during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer rooms was free of lint and other debris. LSC 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect mostly laundry staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., the floor, walls, ceiling, and dryers in the room behind the dryers in the laundry area were substantially covered with dryer lint. Based on interview at the time of observation, the MD agreed there was a substantial amount of dryer lint within the room behind the dryers and further said the area would need to be cleaned. The findings were reviewed with the Maintenance Director at the time of discovery and again with		potential to be affected by the same deficient practice and what corrective action will be taken? - all residents have the same potential to be affected by this alleged deficient practice. - the cookie box in question was immediately removed. the lint in question has been removed from the floor, walls and ceiling in the laundry area. IDT, therapy, maintenance and laundry educated by the senior Executive Director by 2/24/24 on combustible material on the range and lint in the laundry room. 3) what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? - the cookie box in question was removed immediately. the lint in question has been removed from the floor, walls and ceiling in the laundry area. - IDT, therapy , maintenance and laundry educated by the senior E.D. by 2/24/24 combustible material on the range and lint in the laundry room. - Maintenance/designee to conduct audits to ensure compliance (see attachment C). 4.) how the corrective action(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place; - ongoing compliance with this corrective action will be monitored via facility QAPI program, with	

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	the MD and Senior Executive Director during the exit conference. 3.1-19(b)		meetings being held every other month, and is overseen by the Executive Director. - CQI tool identified as life safety poc (see attachment C) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. - If threshold of 100% is not met, an action plan will be developed to ensure compliance. 5) By what date the systemic changes will be completed; completion date : 2/24/24	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the therapy area. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop	K 0324	we respectfully request desk review in regards to this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - no residents were affected by this alleged deficient practice. - range is powered off and staff have access to power source. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; -	02/24/2024

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	or range whenever the kitchen is not under staff supervision. This deficient practice could affect up to 10 residents and staff in the therapy area. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., there was an electric range in the therapy area that was powered on and not in use. The Maintenance Director was asked if staff knew how to deactivate the range when not in use and he indicated that the shut off was above the appliance in a cabinet. The findings were reviewed with the Maintenance Director at the time of discovery and again with the MD and Senior Executive Director during the exit conference. 3.1-19(b)		All residents/staff have the same potential to be affected by this alleged deficient practice. - range is powered off and staff have access to power source.- therapy, idt and maintenance staff were educated by the Senior Executive Director by 2/24/24 on location of power source to therapy range and need of power off when not in use. . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - range powered off and staff have access to power source. - education provided to idt, therapy staff and maintenance by the Senior Executive Director by 2/24/24 on location of power source and need to power off when not in use. - Maintenance/designee to audit to ensure range powered off when not in use. (see attachment C). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality	

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			assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as life safety poc audits (see attachment C) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 2/24/24	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure sprinkler heads behind the dryers were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the	K 0353	we respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - no residents were affected by this alleged deficient practice. - sprinkler head in laundry area cleaned/repaired accordingly and sprinkler head is not loaded or covered with foreign	02/24/2024

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	sprinkler manufacturer. This deficient practice could affect staff mainly in the laundry area. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., the sprinkler head in the room behind the dryers was coved in lint or showed signs of loading. The findings were reviewed with the Maintenance Director at the time of discovery and again with the MD and Senior Executive Director during the exit conference. 3.1-19(b)		material. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents/staff have the same potential to be affected by this alleged deficient practice. - sprinkler head in laundry area cleaned/repaired accordingly and sprinkler head is not loaded or covered with foreign material. - IDT/ Maintenance personnel educated by the Senior Executive Director by 2/24/24 on the maintenance of sprinkler heads (see attachment A). . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - sprinkler head in laundry area cleaned/repaired accordingly and sprinkler head is not loaded or covered with foreign material. - IDT/Maintenance personnel was educated by the Senior Executive Director by 2/24/24 on the	

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			sprinkler head maintenance. (see attachment A) - Maintenance to audit sprinkler heads to keep them free from loading and free from foreign material. (see attachment C) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as life safety audits (see attachment C) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 2/24/24	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility	K 0363	we respectfully request desk	02/24/2024

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	failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 8 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., the following corridor doors failed to latch positively into their respective door frames: a) Clear Laundry near the Service Hall - the door was sticking on the floor as it attempted to close and failed to close and latch. b) Housekeeping Closet in the Kitchen Service Corridor. c) Medical Records Office had a magnet over the latch. Staff stated that "we have to do it so we can get in and out." The findings were reviewed with the Maintenance Director at the time of discovery and again with the MD and Senior Executive Director during the exit conference. 3.1-19(b)		review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - no residents were affected by this alleged deficient practice. - the housekeeping closet, clean laundry and the medical records office doors have been corrected and latch positively. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents/staff have the same potential to be affected by this alleged deficient practice. - the housekeeping closet, clean laundry and the medical records office doors have been corrected and latch positively. - IDT/Maintenance personnel have been educated by the Senior Executive Director by 2/24/24 on corridor doors latching positively. (see attachment A) .	

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			What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - the housekeeping closet door, clean laundry door and the medical records office door have been corrected and latch positively. - IDT/ Maintenance personnel have been educated by the Senior Executive Director by 2/24/24 on corridor doors latching positively. (see attachment A). - Maintenance Director/designee will audit to ensure corridor doors latch positively (see attachment C). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as life safety poc audits (see attachment C) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until	

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K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions in 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review and interview with the Maintenance Director on 02/08/24 between 9:30 a.m. and 11:20 a.m., the following shifts did not have fire drills at unexpected times: a. 3 of 4 First Shift fire drills took place around 7:00 a.m. b. 4 of 4 Second Shift fire drills took place around 3:00 p.m. c. 4 of 4 Third Shift fire drills took place around 5:00 a.m. Based on interview at the time of record review, the Maintenance Director agreed fire drills for all three shifts were not held at unexpected times. The findings were reviewed with the Maintenance Director at the time of discovery and again with the MD and Senior Executive Director during the exit conference. 3.1-19(b)	K 0712	compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 2/24/24 we respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - no residents were affected by this alleged deficient practice. - Fire drills conducted since 2/8/24 and ongoing to be completed with staggering times implemented from month to month. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents/staff have the same potential to be affected by this alleged deficient practice. -Fire drills conducted since 2/8/24	02/24/2024

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	3.1-51(c)		and ongoing to be completed with staggering times from month to month. - Education provided to the IDT/ Maintenance on fire drill policy and staggering of times. (see attachment A). . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - fire drills conducted since 2/8/24 and ongoing to be completed with staggering times from month to month. - Education provided to IDT/Maintenance on fire drill policy and staggering of times. (see attachment A) - Maintenance Director/designee to audit fire drill times to ensure times are staggered. (see attachment C) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held	

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			every other month, and is overseen by the Executive Director. CQI tool identified as life safety audits poc (see attachment C) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 2/24/24	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect 5 staff and residents in the smoking area. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., in the smoking area in the rear of the facility near the generator, there were over 30 cigarette butts disposed on the ground in and around the smoking area and exit door. Based on interview at the time of observations, the MD concluded there were over 30 cigarette butts on the ground in the aforementioned location.	K 0741	we respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - no residents were affected by this alleged deficient practice. - The smoking area is clean and being maintained. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	02/24/2024

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	The findings were reviewed with the Maintenance Director at the time of discovery and again with the MD and Senior Executive Director during the exit conference. 3.1-19(b)		action(s) will be taken; All residents/staff have the same potential to be affected by this alleged deficient practice. - the smoking area is clean and being maintained. - Education to provided to all staff by the Senior Executive Director by 2/24/24 on keeping the smoking area maintained and disposing of cigarette butts appropriately. (see attachment A) . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - - Education provided by the Senior Executive Director to all staff by 2/24/24 on keeping the smoking area maintained and disposing of cigarette butts appropriately (see attachment A)- Maintenance Director/designee will conduct audits to ensure compliance of the smoking area (see attachment C). How the corrective action(s) will be monitored to ensure the deficient	

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	155786	A. BUILDING 01 B. WING	02/08/2024

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			practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as life safety audits (see attachment C) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 2/24/24	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 power strips in the Social Services Office were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents and 2 staff. Findings include: Based on observations and interview during a	K 0920	we respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; no residents were affected by this alleged deficient practice. - power strips in use meet UL standards including social services office with some	02/24/2024

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	tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., a refrigerator, microwave and coffee machine (high power draw equipment) were plugged into and supplied power by a power strip in the Social Services office. Based on interview at the time of observation, the Maintenance Director acknowledged the power strip was supplying power to high power draw equipment. The findings were reviewed with the Maintenance Director at the time of discovery and again with the MD and Senior Executive Director during the exit conference. 3.1-19(b)		appliances removed. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents/staff have the same potential to be affected by this alleged deficient practice. - power strips in use meet UL standards including social services office with some appliances removed. - Education provided to IDT/Maintenance/ Social services by the Senior Executive Director by 2/24/24 on power strip usage. (see attachment A). . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - Education provided to IDT/Maintenance/social services by the Senior Executive Director by 2/24/24 on power strip usage. (see attachment A). - Maintenance Director/designee to audit on appropriate power strip	

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			usage. (see attachment C). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as life safety audits poc (see attachment C) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 2/24/24	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen trans-filling rooms. NFPA 99, 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from	K 0923	we respectfully request desk review in this matter. Thank you for your consideration. What corrective action(s) will be	02/24/2024

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	combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect 25 residents in one smoke compartment. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 02/08/24 between 11:20 a.m. and 1:30 p.m., 4 large cardboard boxes containing water were being stored on shelving in the Oxygen Storage and Transfilling area. Based on interview at the time of observation, the Maintenance Supervisor agreed combustible materials in the form of cardboard boxes were stored within five feet of liquid oxygen containers. The findings were reviewed with the Maintenance Director at the time of discovery and again with the MD and Senior Executive Director during the exit conference. 3.1-19(b)		accomplished for those residents found to have been affected by the deficient practice; - no residents were affected by this alleged deficient practice. - cardboard boxes containing water have been removed from this area. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents/staff have the same potential to be affected by this alleged deficient practice. - cardboard boxes containing water have been removed from this area. - Education provided to IDT/Maintenance / nursing staff by the Senior Executive Director by 2/24/24 on storage of combustible items in oxygen storage room. (see attachment A). . What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - boxes removed from the oxygen storage room. - Education	

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			provided to IDT/Maintenance/nursing staff by the Senior Executive Director by 2/24/24 on storage of combustible items in oxygen storage room. (see attachment A). - Audits to be conducted by Maintenance Director/designee to ensure no combustible items are being stored in the oxygen storage room. (see attachment C) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as life safety audits (see attachment C) will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 2/24/24	

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